Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

MEDICAL ASSISTANCE ADMINISTRATION

Long Term Acute Care (LTAC) Program

Billing Instructions

WAC 388-550-2565 through 2595

About this publication

This publication supersedes all previous MAA Long Term Acute Care (LTAC) Program Billing Instructions and Numbered Memoranda.

Published by the Medical Assistance Administration
Washington State Department of Social and Health Services

Note: The effective date and publication date for any particular page of this document may be found at the bottom of the page.

Received too many billing instructions?
Too few?
Address incorrect?

Please detach, fill out, and return the card located inside the back cover of this billing instruction. The information you provide will be used to update our records and provider information.

Table of Contents

Important Contacts

A provider may use MAA's toll-free lines for questions regarding its programs; however, MAA's response is based solely on the information provided to the [MAA] representative at the time of the call or inquiry, and in no way exempts a provider from following the rules and regulations that govern MAA's programs. [WAC 388-502-0020(2)].

Where do I call for information to become a DSHS provider, to submit a change of address or ownership, or to ask questions about the status of a provider application?

Provider Enrollment Unit
(866) 545-0544

Where do I send my claims?

Hard Copy Claims:
Division of Program Support
PO Box 9246
Olympia, WA 98507-9246

Magnetic Tapes/Floppy Disks:
Division of Program Support
Claims Control
PO Box 45560
Olympia, WA 98504-5560

How do I obtain copies of billing instructions or numbered memoranda?

Check out our web site at: http://maa.dshs.wa.gov, Provider Publications/Fee Schedules link.

Who do I contact if I have questions regarding…

Policy, payments, denials, general questions regarding claims processing, Healthy Options, or to request billing instructions?

Provider Relations Unit
(800) 562-6188

Prior Authorization?

LTAC Program Manager
Division of Medical Management
(360) 725-1575
(360) 586-1471 Fax

Private insurance or third-party liability, other than Healthy Options?

Coordination of Benefits Section
(800) 562-6136

Electronic Billing?

Electronic Media Claims Help Desk
(360) 725-1267

Internet Billing?

http://wamedweb.acs-inc.com

Definitions

This section defines terms and acronyms used in these billing instructions.

Acute - An intense medical episode, not longer than two months.

Administrative Day - A day of a hospital stay in which an acute inpatient level of care is no longer necessary, and noninpatient hospital placement is appropriate. [WAC 388-550-1050]

Administrative Day Rate - The statewide Medicaid average daily nursing facility rate as determined by the department.

Authorization - MAA official approval for action taken for, or on behalf of, an eligible Medical Assistance client. This approval is only valid if the client is eligible on the date of service.

Authorization Number - A nine-digit number assigned by MAA that identifies individual requests for approval of services. The same authorization number is used throughout the history of the request, whether it is approved, pended, or denied. [WAC 388-550-1050]

Client - An individual who has been determined eligible to receive medical or health care services under any MAA program.

Code of Federal Regulations (CFR) - Rules adopted by the federal government.

Core Provider Agreement - The basic contract between MAA and an entity providing services to eligible clients. The core provider agreement outlines and defines terms of participation in medical assistance programs.

Department - The state Department of Social and Health Services (DSHS).

Diagnosis Related Group (DRG) - A classification system which categorizes hospital patients into clinically coherent and homogenous groups with respect to resource use, i.e., similar treatments and statistically similar lengths of stay for patients with related medical conditions. Classification of patients is based on the International Classification of Diseases, the presence of a surgical procedure, patient age, presence or absence of significant co-morbidities or complications, and other relevant criteria. [WAC 388-550-1050]

Division of Medical Management (DMM) - A division within the Medical Assistance Administration responsible for the administration of the quality improvement and assurance programs, utilization review and management, and prior authorization for fee-for-service programs.

Eligible Client – A DSHS client eligible for Level 1 or Level 2 LTAC services. [WAC 388-550-2570]

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medicare Benefits (EOMB) – A federal report generated for Medicare providers displaying transaction information regarding Medicare claims processing and payments.

Family – Individuals who are important to and designated by the patient or client and need not be related. [WAC 388-550-2570]

Level 1 Services – Long term acute care (LTAC) services provided to clients who require more than eight hours of direct skilled nursing care per day. Level 1 services include one or both of the following:

- Active ventilator weaning care and any specialized therapy services, such as physical, occupational, and speech therapies; or

- Complex medical care that may include:

  - ✓ Care for complex draining wounds;
  - ✓ Care for central lines;
  - ✓ Multiple medications (intravenous);
  - ✓ Frequent assessments and close monitoring;
  - ✓ Third degree burns that may involve grafts and/or frequent transfusions; and
  - ✓ Specialized therapy services, such as physical, occupational, and speech therapies. [WAC 388-550-2570]

Level 2 Services – Long term acute care (LTAC) services provided to clients who require four to eight hours of direct skilled nursing care per day. Level 2 services include at least two of the following:

- Ventilator care for clients who are stable, dependent on a ventilator, and have complex medical needs;
- Care for clients who have: tracheostomies, complex airway management and medical needs, and the potential for decannulation; and
- Specialized therapy services, such as physical, occupational, and speech therapies. [WAC 388-550-2570]

Long Term Acute Care (LTAC) – Inpatient intensive long term acute care services provided in MAA-approved LTAC facilities to eligible Medical Assistance clients who require Level 1 or Level 2 services. [WAC 388-550-2570]

LTAC Fixed Per Diem Rate- The daily rate MAA reimburses for LTAC room and board and selected services.

Managed Care - A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services.
[WAC 388-538-050]

Maximum Allowable - The maximum dollar amount MAA will reimburse a provider for a specific service, supply, or piece of equipment.

Medicaid - The state and federally funded Title XIX program under which medical care is provided to persons eligible for the categorically needy program or medically needy program.

Medical Assistance Administration (MAA) - The administration within DSHS authorized by the secretary to administer the acute care portion of Title XIX Medicaid, Title XXI state-children's health insurance program (S-CHIP), Title XVI, and the state-funded medical care programs, with the exception of certain nonmedical services for persons with chronic disabilities.

Medical Identification card – The document MAA uses to identify a client's eligibility for a medical program. These cards were formerly known as medical assistance identification (MAID) cards.

Medically Necessary - A term for describing [a] requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

Medicare - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare. [WAC 388-500-0005]

Multidisciplinary Team - A team that coordinates individualized LTAC services at an MAA-approved inpatient rehabilitation facility to achieve the following for the client:

- Improved health and welfare; and
- Maximum physical, social, psychological, and vocational potential.

Noncovered Service or Charge - A service or charge that is not covered by the Medical Assistance Administration, including, but not limited to, such services or charges as a private room, circumcision, and video recording of the procedure. [WAC 388-550-1050]

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each MAA client and that consists of:

- First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

Program Support, Division of (DPS) – The division within MAA responsible for providing administrative services for the following:

- Claims Processing;
- Family Planning Services;
- Administrative Match Services to Schools and Health Departments; and

Managed Care Contracts

Provider or Provider of Service – An institution, agency, or person:

- Who has a signed agreement [Core Provider] with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department.

Ratio of Costs-to-Charges (RCC) - The methodology used to pay hospitals for services exempt from the DRG payment method. It also refers to the factor applied to a hospital's allowed charges for medically necessary services to determine payment to the hospital for these DRG-exempt services. [WAC 388-550-1050]

Remittance and Status Report (RA) - A report produced by Medicaid Management Information System (MMIS), MAA's claims processing system, that provides detailed information concerning submitted claims and other financial transactions.

Review – See Survey.

Revised Code of Washington (RCW) – Washington state law.

Short-term – Two months or less.

Survey – An inspection conducted by a federal, state, or private agency to evaluate and monitor a facility's compliance with LTAC program requirements.

Third-Party - Any individual, entity, or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan. [42 CFR 433.136]

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.

Transportation Company – Either an MAA-approved transportation broker or a transportation company doing business with MAA.

Usual & Customary Fee - The fee that the provider typically charges the general public for the product or service.

Washington Administrative Code (WAC) - Codified rules of the State of Washington.

About the Program

What is the Long Term Acute Care (LTAC) Program?

[Refer to WAC 388-550-2565]

- The long term acute care (LTAC) program is a 24-hour inpatient comprehensive program of integrated medical and rehabilitative services provided in a Medical Assistance Administration (MAA)-approved LTAC facility during the acute phase of a client's care. These facilities specialize in treating patients requiring intensive hospitalization for extended periods of time. Patients transferred to these hospitals are typically in the intensive care unit of the traditional hospital that initiated their medical care. Under federal guidelines, only a few hospitals have been designated as specialists in treating patients requiring intensive medical care for extended periods. Medicare calls these hospitals "long term acute care hospitals" (LTAC).

- MAA requires prior authorization for all LTAC stays. See the "*What are the requirements for prior authorization?"* on page D.1.

- A multidisciplinary team coordinates individualized LTAC services at an MAA-approved LTAC facility to achieve improved health and welfare for a client.

- MAA determines the authorized length of stay for LTAC services based on the client's need as documented in the client's medical records and the criteria described in the "*What are the requirements for prior authorization?*" on page D.1.

- When the MAA-authorized length of stay ends, the provider transfers the client to a more appropriate level of care or, if appropriate, discharges the client to the client's residence.

This is a blank page…

Client Eligibility

Who is eligible? [Refer to WAC 388-550-2575]

Clients presenting Medical Identification cards with the following program identifiers **are eligible** for LTAC services:

Medical Identification Card Identifier	Medical Program
CNP	Categorically Needy Program
CNP **CHIP**	Categorically Needy Program - Children's Health Insurance Program
CNP **Emergency Medical Only**	Categorically Needy Program – Emergency Medical Only
LCP-MNP	Limited Casualty Program – Medically Needy Program
LCP-MNP **Emergency Medical Only**	Limited Casualty Program– Medically Needy Program - Emergency Medical Only

Are clients enrolled in managed care eligible for LTAC services?

Yes! Clients whose Medical Identification cards have an HMO identifier in the HMO column are enrolled in a managed care plan and are eligible for LTAC services through their plan. If a client is enrolled in an MAA managed care plan at the time of acute care admission, that plan pays for and coordinates LTAC services as appropriate. The plan's 1-800 telephone number is located on the client's Medical Identification card. MAA does not process or reimburse claims for Healthy Options managed care clients for services provided under the Healthy Options contract.

☞ **Note:** To prevent claim denials, please check the client's Medical Identification card **prior** to scheduling services and at the **time of service** to make sure proper authorization or referral is obtained from the plan.

Primary Care Case Management (PCCM)

For the client who has chosen to obtain care with a PCCM, the identifier in the HMO column will be "PCCM." These clients must obtain, or be referred for, services via the PCCM. The PCCM is responsible for coordination of care just like the primary care provider (PCP) would be in a plan setting. Please refer to the client's Medical Identification card for the PCCM. (See the *Billing* section for further information.)

Note: To prevent billing denials, please check the client's Medical Identification card prior to scheduling services and at the time of the service to make sure proper authorization or referral is obtained from the PCCM.

Provider Requirements

How does a facility become an LTAC Provider?

[Refer to WAC 388-550-2580]

To apply to become an MAA-approved LTAC facility, MAA requires a hospital provider to:

- Submit a letter of request to:

  LTAC Program Manager
  Division of Medical Management
  Medical Assistance Administration
  PO Box 45506
  Olympia, WA 98504-5506

-AND-

- Include documentation that confirms the facility is:

  - ✓ Medicare certified for LTAC;
  - ✓ Accredited by the Joint Commission on Accreditation of Hospital Organizations (JCAHO);
  - ✓ Licensed by the Department of Health (DOH) as an acute care hospital as defined under WAC 246-310-010; and
  - ✓ Contracted under MAA's selective contracting program, if in a selective contracting area, unless exempted from the requirements by MAA.

The hospital facility qualifies as an MAA-approved LTAC facility when:

- The facility meets all the requirements in this section;
- MAA's clinical staff has conducted a facility site visit; and
- MAA provides written notification that the facility qualifies to be reimbursed for providing LTAC services to eligible medical assistance clients.

MAA-approved LTAC facilities must meet the general provider requirements found in MAA's current General Information Booklet.

Postpay/On-site Reviews [WAC 388-550-2585]

To ensure quality of care, MAA may conduct postpay or on-site reviews of any MAA-approved LTAC facility. See WAC 388-502-0240, "Audits and the audit appeal process for contractors/providers," for additional information about audits conducted by department staff.

To ensure a client's right to receive necessary quality of care, a provider of LTAC services is responsible to act on any reports of substandard care or violations to the facility's medical staff bylaws. The provider must have and follow written procedures that provide a resolution to either a complaint or a grievance or both. A complaint or grievance regarding substandard conditions or care may be investigated by any one or more of the following:

- The Department of Health (DOH);
- The Joint Commission on Accreditation of Hospital Organizations (JCAHO);
- MAA; or
- Other agencies with review authority for medical assistance programs.

Notifying Clients of Their Rights (Advance Directives)
[42 CFR, Subpart I]

All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give **all adult clients** written information about their rights, under state law, to make their own health care decisions.

Clients have the right to:

- Accept or refuse medical treatment;
- Make decisions concerning their own medical care; and
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

Prior Authorization

Is prior authorization required for LTAC services?
[Refer to WAC 388-550-2590]

YES!

What are the requirements for prior authorization?

MAA requires prior authorization for Level 1 and Level 2 LTAC (see *Definitions* on page iv) inpatient stays. The prior authorization process includes all of the following:

- For an initial 30-day stay:
  - ✓ The client must:
    - ➢ Be eligible for LTAC services (see *Who is eligible?* on page B.1);
    - ➢ Meet the high cost outlier status at the transferring hospital as described in WAC 388-550-3700; and
    - ➢ Require Level 1 or Level 2 services (see *Definitions* on page iv).
  - ✓ The LTAC provider must:
    - ➢ Submit a request for prior authorization to the MAA clinical consultation team by fax or telephone before admitting the client to the LTAC facility; and
    - ➢ Include sufficient medical information to justify the requested initial stay.
- For extensions of stay:
  - ✓ The client must:
    - ➢ Be eligible for LTAC services (see *Who is eligible?* on page B.1); and
    - ➢ Require Level 1 or Level 2 services (see *Definitions* on page iv).

- ✓ The LTAC provider must:
  - ➢ Submit a request for the extension of stay to the MAA clinical consultation team by fax or telephone before the client's current authorized period of stay expires; and
  - ➢ Include sufficient medical information to justify the requested extension of stay.

The MAA clinical consultation team authorizes Level 1 or Level 2 LTAC services for initial stays or extensions of stay based on the client's circumstances and the medical justification received. MAA notifies the client and provider of their decision in writing. A client who does not agree with a decision has a right to a fair hearing under chapter 388-02 WAC. After receiving a request for a fair hearing, MAA may request additional information from the client and/or the facility. After MAA reviews the available information, the result may be:

- A reversal of the initial MAA decision;
- Resolution of the client's issues; or
- A fair hearing conducted per chapter 388-02 WAC.

MAA may authorize administrative day rate reimbursement for a client who:

- Does not meet the requirements described in this section;
- Is waiting for placement in another facility; or
- Is waiting to be discharged to the client's residence.

☞ **Note:** To bill administrative days:
1. Bill on a separate claim form.
2. Use your MAA LTAC provider number in form locator 51.
3. Use LTAC authorization number in form locator 63.
4. Use revenue code 169 for room and board charges in form locator 42. **MAA reimburses for revenue codes 169 and 250 (pharmacy) only.**
5. For admission, put original date admitted to LTAC facility in form locator 17.

TO REQUEST PRIOR AUTHORIZATION
Send a fax to the DMM Medical Program Management Unit (see Important Contacts)

Reimbursement

What does the LTAC fixed per diem rate include?

[Refer to WAC 388-550-2595 (1)]

In addition to room and board, the LTAC fixed per diem rate includes, but is not limited to, the services and equipment in the table below. Use revenue code 100 in form locator 47 on the UB-92 claim form when billing for the services included in the fixed per diem rate. The amount billed must be the usual and customary charges for the services included in the per diem rate. MAA reimburses for these services at MAA's LTAC fixed per diem rate.

☞ **Note:**
- Bill the Usual and customary charges for all charges incurred for services included in the fixed per diem rate under revenue code 100.
- Do not bill separately for any of the codes revenue codes listed below as these charges should be included in your charges for revenue code 100. **Exception: revenue code 250, see instruction in note on E3.**

Revenue Code	Description
100	**Your usual and customary charges for the following services are included and should be billed under revenue code 100. MAA reimburses for these services at MAA's LTAC fixed per diem rate.:**
128	Room and Board – Rehabilitation
200	Room and Board – Intensive Care
250	Pharmacy - Up to and including $200 per day in total allowed charges for any combination of pharmacy services that includes prescription drugs, total parenteral nutrition (TPN) therapy, IV infusion therapy, and/or epogen/neupogen therapy.
270	Medical/Surgical Supplies and Devices
300	Laboratory – General
301	Laboratory – Chemistry
302	Laboratory – Immunology
305	Laboratory – Hematology
306	Laboratory – Bacteriology and Microbiology
307	Laboratory – Urology
309	Laboratory – Other Laboratory Services
410	Respiratory Services
420	Physical Therapy
430	Occupational Therapy
440	Speech-Language Therapy

What is not included in the LTAC fixed per diem rate?

[Refer to WAC 388-550-2596 (1)]

The following specific services and equipment are excluded from the LTAC fixed per diem rate and may be billed by providers in accordance with applicable MAA fee and/or rate schedules:

☞ **Note:** Bill your total usual and customary charges for revenue code 250 in form locator 47. Enter the first $200.00 per day in locator 48 as noncovered.

Revenue Code	Description
250	Pharmacy - After the first $200 per day in total allowed charges for any combination of pharmacy services that includes prescription drugs, total parenteral nutrition (TPN) therapy, IV infusion therapy, and/or epogen/neupogen therapy.
255	Drugs/Incidental Radiology
260	IV Therapy
320	Radiology
340	Nuclear Medicine
350	Computered Tomographic (CT) Scan
360	Operating Room Services
370	Anesthesia
390	Blood and Blood Component, Processing and Storage
391	Blood and Blood Component, Administration
402	Other Imaging Services – Ultrasound
460	Pulmonary Function
480	Cardiology
710	Recovery Room
730	EKG/ECG
750	Gastro-Intestinal Services
801	Inpatient Hemodialysis
921	Peripheral Vascular Lab

☞ **Note:** MAA uses the appropriate payment method described in MAA's other billing instructions to reimburse providers other than LTAC facilities for services and equipment that are covered by MAA but not included in the LTAC fixed per diem rate. The provider must bill MAA directly and MAA reimburses the provider directly. **[Refer to WAC 388-550-2596 (2)]**

How is reimbursement determined for LTAC services?
[WAC 388-550-2595 (2)]

MAA pays the LTAC facility the LTAC fixed per diem rate in effect at the time the LTAC services are provided, minus the sum of:

- Client liability, whether or not collected by the provider; and
- Any amount of coverage from third parties, whether or not collected by the provider, including, but not limited to, coverage from:
  - ✓ Insurers and indemnitors;
  - ✓ Other federal or state medical care programs;
  - ✓ Payments made to the provider on behalf of the client by individuals or organizations not liable for the client's financial obligations; and
  - ✓ Any other contractual or legal entitlement of the client, including, but not limited to:
    - ➢ Crime victims' compensation;
    - ➢ Workers' compensation;
    - ➢ Individual or group insurance;
    - ➢ Court-ordered dependent support arrangements; and
    - ➢ The tort liability of any third party.

☞ **Note:** MAA may make annual rate increases to the LTAC fixed per diem rate by using the same inflation factor and date of rate increase that MAA uses for acute care hospital diagnostic-related group (DRG) rates. This DRG rate adjustment method is described in WAC 388-550-3450 (5). [WAC 388-550-2595 (3)]

Does MAA reimburse for Ambulance Transportation?
[WAC 388-550-2596 (3)]

Transportation services provided to a client after admission to an LTAC facility, but prior to discharge, that are related to transporting the client to and from another facility for the provision of outpatient medical services:

- Are not covered or reimbursed through the LTAC fixed per diem rate; and
- Must be billed directly to MAA by the transportation company to be reimbursed.

This is a blank page...

Billing

What is the time limit for billing? [Refer to WAC 388-502-0150]

MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards for: 1) initial claims; and 2) resubmitted claims.

- **Initial Claims**

  ✓ MAA requires providers to obtain an ICN for an **initial claim** within 365 days from any of the following:

  - The date the provider furnishes the service to the eligible client;
  - The date a final fair hearing decision is entered that impacts the particular claim;
  - The date a court orders MAA to cover the services; or
  - The date DSHS certifies a client eligible under delayed[1] certification criteria.

  ✓ MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

  - DSHS certification of a client for a retroactive[2] period; or
  - The provider proves to MAA's satisfaction that there are extenuating circumstances.

---

[1] **Delayed Certification -** According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

[2] **Retroactive Certification -** According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill MAA for the service.

- **Resubmitted Claims**

  Providers may **resubmit, modify, or adjust** any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

  ☞ **Note:** MAA does not accept any claim for resubmission, modification, or adjustment after the time period listed above.

- The time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:

  ✓ The provider fails to meet these listed requirements; and
  ✓ MAA does not pay the claim.

What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary fee**.**

☞ **Exception:** If billing Medicare Part B crossover claims, bill the amount submitted to Medicare.

How do I bill for services provided to Primary Care Case Management (PCCM) clients?

When billing for services provided to PCCM clients:

- Enter the referring physician or PCCM name in form locator #83 on the UB-92 claim form; and
- Enter the seven-digit, MAA-assigned identification number of the PCCM who referred the client for the service(s). If the client is enrolled with a PCCM and the PCCM referral number is not in form locator #83 when you bill MAA, the claim will be denied.

How do I bill for a client who is eligible for both Medicare and Medicaid?

If a client is eligible for both Medicare and Medicaid (otherwise known as "dually- eligible"), **you must <u>first</u> submit a claim to Medicare and accept assignment within Medicare's time limitations**. MAA may make an additional payment after Medicare reimburses you.

- If Medicare pays the claim, the provider must bill MAA within six months of the date Medicare processes the claim.
- If Medicare denies payment of the claim, MAA requires the provider to meet MAA's initial 365-day requirement for initial claim (see page F.1).
- Codes billed to MAA must match codes billed to Medicare when billed as a Medicare Part B crossover claim.

Medicare Part A

Medicare Part A is a health insurance program for:

- Individuals who are 65 years of age and older;
- Certain individuals with disabilities (under 65 years of age); or
- Individuals with End-Stage Renal Disease (permanent kidney failure requiring dialysis or transplant).

Medicare Part A helps individuals pay for hospital stays, skilled nursing facilities, hospice and some home health care. Check the client's red, white and blue Medicare card for the words "Part A (hospital insurance)" in the lower left corner of the card to determine if they have Medicare Part A coverage.
Under Part A, Medicare will pay its allowed charges, minus any deductible and/or coinsurance, when appropriate.

Effective April 1, 1999, payments for services rendered to Qualified Medicare Beneficiaries (QMBs) is limited to the Medicare payment if the Medicare payment exceeds the amount MAA would pay for the same service (whether normally DRG or RCC reimbursed) had the service been reimbursed under the ratio of costs-to-charges (RCC) payment method.

When billing Medicare:

- Indicate *Medical Assistance* and include the patient identification code (PIC) on the claim form as shown on the Medical Identification card. Enter the Medical Assistance provider number.
- Accept assignment.
- If Medicare has allowed the service, in most cases Medicare will forward the claim to MAA. MAA then processes your claim for any supplemental payments.
- If Medicare does not forward your claim to MAA **within 30 days** from its statement date, send the UB-92 claim form and a copy of the Part A Explanation of Medical Benefits (EOMB) to MAA for processing.
- When Part A services are totally disallowed by Medicare but are covered by MAA, bill MAA on the UB-92 claim form and attach copies of Medicare's EOMB with the denial reasons.

☞ **Note:**

- ✓ Medicare/Medical Assistance billing claims must be received by MAA within six (6) months of Medicare's EOMB paid date.
- ✓ A Medicare Remittance Notice or EOMB must be attached to each claim.

QMB (Qualified Medicare Beneficiaries) Program Limitations:

QMB with CNP or MNP (Qualified Medicare Beneficiaries with Categorically Needy Program or Medically Needy Program)

(Clients who have CNP or MNP identifiers on their Medical Identification card in addition to QMB)

- If Medicare **and** Medicaid cover the service, MAA will pay only the deductible and/or coinsurance up to Medicare or Medicaid's allowed amount, whichever is less.

- If only Medicare **and not Medicaid** covers the service, MAA will pay only the deductible and/or coinsurance up to Medicare's allowed amount.

- If Medicaid covers the service and Medicare does not cover the service, MAA will reimburse for the service.

QMB-Medicare Only

The reimbursement criteria for this program are as follows:

- If Medicare **and** Medicaid cover the service, MAA will pay only the deductible and/or coinsurance up to Medicare or Medicaid's allowed amount, whichever is less.

- If only Medicare **and not Medicaid** covers the service, MAA will pay only the deductible and/or coinsurance up to Medicare's allowed amount.

For QMB-Medicare Only:
If **Medicare does not** cover the service or when Medicare coverage ends, MAA will not reimburse the service.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's Medical Identification card. An insurance carrier's time limit for claim submissions may be different from MAA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as MAA's, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you haven't received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA;
- Attach the insurance carrier's statement or EOB;
- If rebilling, also attach a copy of the MAA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the *Comments* field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on MAA's website at http://maa.dshs.wa.gov, Provider Publications/Fee Schedules, then open Billing Instructions, then go to General Info Booklet. Carrier codes are listed there. You may also call the Coordination of Benefits Section at 1-800-562-6136.

What records must be kept? [Refer to WAC 388-502-0020]

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, for at least six years from the date of service or more if required by federal or state law or regulation.

A provider may contact MAA with questions regarding MAA's programs. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs. (Refer to WAC 388-502-0020[2])

How to Complete the UB-92 Claim Form

Only form locators that pertain to billing MAA are addressed below.

When submitting more than one page of the UB-92, be sure to fully complete the first page. Only the *detail lines* are picked up from the second page. Please clearly indicate Page 1 of 2, Page 2 of 2, etc., in the *Remarks* section (*form locator 84*).

If a client is not eligible for the entire hospital stay, bill only dates of service for which the client is eligible.

When billing electronically, indicate claim type "S" for RCC.

☞ **Note:** Shaded fields are required fields only for UB-92 Medicare/Medicaid Crossover Claims." **Medicare/Medicaid Crossover Claims cannot be billed electronically.**

FORM LOCATOR NAME AND INSTRUCTIONS FOR COMPLETION:

1. **Provider Name, Address & Telephone Number** - Enter the provider name, address, and telephone number as filed with the MAA Division of Program Support (DPS).

3. **Patient Control No.** - This is a 20-digit alphanumeric entry **that you may use as your internal reference number**. You create this number. Once you have submitted this account number to MAA, it will appear on the Remittance and Status Report under the column titled *Patient Account Number*.

4. **Type of Bill** - Indicate type of bill using 3 digits as follows:

Type of Facility (first digit)
1 = Hospital

Bill Classification (second digit)
1 = Inpatient

Frequency (third digit)
1 = Admit through discharge claim
2 = Interim - First Claim
3 = Interim - Continuing Claim
4 = Interim - Last Claim
5 = Late Charge(s) Only Claim

6. **Statement Covers Period** - Enter the beginning and ending dates of service for the period covered by this bill.

12. **Patient Name** - Enter the client's last name, first name, and middle initial as shown on the client's medical identification card.

13. **Patient's Address** - Enter the client's address.

14. **Patient's Birthdate** - Enter the client's birthdate.

15. **Patient's Sex** - Enter the client's sex.

17. **Admission Date** - Enter the date of admission (MMDDYY).

18. **Admission Hour** - The hour during which the patient was admitted for outpatient care. Use the appropriate two-digit code listed in the following list:

Code	Time: A.M.	Code	Time: P.M.
00	12:00 - 12:59 (Midnight)	12	12:00 - 12:59 (Noon)
01	01:00 - 01:59	13	01:00 - 01:59
02	02:00 - 02:59	14	02:00 - 02:59
03	03:00 - 03:59	15	03:00 - 03:59
04	04:00 - 04:59	16	04:00 - 04:59
05	05:00 - 05:59	17	05:00 - 05:59
06	06:00 - 06:59	18	06:00 - 06:59
07	07:00 - 07:59	19	07:00 - 07:59
08	08:00 - 08:59	20	08:00 - 08:59
09	09:00 - 09:59	21	09:00 - 09:59
10	10:00 - 10:59	22	10:00 - 10:59
11	11:00 - 11:59	23	11:00 - 11:59

19. **Type of Admission** - Enter type of admission.

1 = Emergent
2 = Urgent
3 = Elective

20. **Source of Admission** - Enter source of admission.

1 = Physician Referral
2 = Clinic Referral
3 = HMO Referral
4 = Transfer from a hospital
5 = Transfer from a nursing facility
6 = Transfer from another health care facility
7 = Emergency Room
8 = Court/Law Enforcement
9 = Information Not Available

21. **Discharge Hour** - The hour during which the patient was discharged from care.

22. **Patient Status** - Enter one of the following codes to represent the disposition of the recipient at discharge:

01 = Discharge to home or self care (routine discharge)
02 = Transferred to another short-term general hospital
03 = Discharged/transferred to nursing facility (SNF)
04 = Discharged/transferred to nursing facility (ICF)
05 = Transferred to an exempt unit or hospital
06 = Discharged/transferred to home under the care of an organized home health service organization
07 = Left against medical advice
08 = Discharged/transferred to home under care of a Home IV Provider
20 = Expired
30 = Still patient

32-35. Occurrence Codes and Dates - Beginning in form locator 32, enter one or more of the following codes, if applicable.

J0 = Baby on mom's PIC
01 = Auto Accident
02 = Auto Accident/No Fault Insurance Involved
03 = Accident/Tort Liability
04 = Accident/Employment Related
05 = Other Accident
06 = Crime Victims
X1 = Trauma Condition Code

39-41. Value Codes and Amounts

39A: **Deductible**: Enter the code *A1*, and the deductible as reported on your EOMB.

39D: **ENC Rate**: Enter Med's ENC rate as reported on the EOMB.

40A: **Coinsurance**: Enter the code *A2*, and the coinsurance as reported on your EOMB.

40D: **Encounter Units**: Enter the encounter units Medicare paid, as reported on EOMB.

41A: **Medicare Payment**: Enter the payment by Medicare as reported on your EOMB.

41D: **Medicare's Process Date**: Enter the date that Medicare processed the claim, as reported on your EOMB in numerals only (*MMDDYY*).

Medicare Crossover claims only

42. **Revenue Code** - Enter the appropriate revenue code(s) from the listing in this manual. Enter *001* for total charges on line 23 of this form locator on the final page.

43. **Revenue or Procedure Description** - Enter a narrative description of the related revenue or procedure codes included on this bill. Abbreviations may be used. Enter the description *total charges* on line 23 of this form locator on the final page.

44. **HCPCS/Rates** - Enter the accommodation rate for inpatient bills.

46. **Units of Service** - Enter the quantity of services listed by revenue or procedure code(s).

47. **Total Charges** - Enter charges pertaining to the related revenue code(s) or procedure code(s). Enter the total of this column as the last detail on line 23 of this form locator on the last page.

48. **Noncovered** - Any noncovered charges pertaining to detail revenue or procedure codes should be entered here. (These services will be *categorically denied*.) Enter the total of this column as the last detail on line 23 of this form locator on the last page.

50. **Payer Identification: A/B/C** - Enter if all health insurance benefits are available.

50A: Enter *Medicaid*.
50B: Enter the name of other insurance.
50C: Enter the name of other insurance.

51. **Provider Number** - Enter the hospital provider number issued to you by DPS. This is the seven-digit provider number beginning with a *3* that appears on your Remittance and Status Report.

Medicare Crossover claims only

51A: Enter the seven-digit Medicaid provider number that appears on your Remittance and Status Report.

51B: Enter your Medicare provider number.

54. **Prior Payments: A/B/C** - Enter the amount due or received from other insurance.

55. **Estimated Amount Due: A/B/C** - The amount estimated by the hospital to be due from the indicated payer (estimated responsibility less prior payments).

57. **Due From Patient - Spenddown**

58. **Insured's Name: A/B/C** - If other insurance benefits are available and coverage is under another name, enter the insured's name.

60. **Cert-SSN-HIC-ID NO.** - Enter the Medicaid Patient (client) Identification Code (PIC) -an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the Medical Identification card. This information is obtained from the client's current monthly Medical Identification card and consists of the client's:

a. First and middle initials (or a dash [-] *must* be used if the middle initial is not available).
b. Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c. First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tie breaker.
d. An alpha or numeric character (tie breaker).

61. **Insurance Group Name** - If other insurance benefits are available, enter the name of the group or the plan through which insurance is provided to the insured.

62. **Insurance Group Number** - If other insurance benefits are available, enter any identification number that identifies the group through which the individual is covered.

63. **Treatment Authorization** - Enter the assigned authorization number (be sure to enter all nine digits).

65. **Employer Name** - If other insurance benefits are available, enter the name of the employer that *might provide* or *does provide* health care coverage insurance for the individual.

67. **Principal Diagnosis Code** - Enter the ICD-9-CM diagnosis code describing the principal diagnosis.

68-75. **Other Diagnosis Codes** - Enter additional ICD-9-CM diagnosis codes indicating any other conditions.

76. **Admitting Diagnosis**

80. **Principal Procedure Code** - The code that identifies the principal procedure performed during the period covered by this bill.

81 A-E **Other Procedure Codes** - The codes identifying all significant procedure(s) other than the principal procedure.

82. **Attending Physician I.D.** - Enter the seven-digit provider identification number of the attending physician. Do not complete this box with a clinic billing number. For attending physicians not enrolled in the Medical Assistance program, enter the name of the attending physician in this form locator.

83. **Other Physician I.D.** - Enter the referring provider number, or if unknown, enter the name of the provider who referred the client to services. If the client is under PCCM, you must use the referring PCCM provider number.

84. **Remarks** - Enter any information applicable to this stay that is not already indicated on the claim form.

APPROVED OMB NO. 0938-0279

LTAC Hospital
123 Main Street
Anytown, WA 99999

3 PATIENT CONTROL NO. 1234567 | 4 TYPE OF BILL 111

5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM 040103 THROUGH 041503 | 7 CCV D. | 8 N-C D. | 9 C-I D. | 10 L-R D. | 11

12 PATIENT NAME: Mary Jane Smith

13 PATIENT ADDRESS: 111 Market Street, Anytown, USA 99999

14 BIRTHDATE	15 SEX	16 MS	17 DATE ADMISSION	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24	25	26	27	28	CONDITION CODES 29	30	31
MMDDYYYY	F		040103	14	2	4	12	01									

32 CODE	OCCURRENCE DATE	33 CODE	OCCURRENCE DATE	34 CODE	OCCURRENCE DATE	35 CODE	OCCURRENCE SPAN FROM	THROUGH	36 A	B	C

	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a						
b						
c						
d						

42 REV. CD	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON COVERED CHARGES	49
100	ROOM & Board	885.00		14	12,390 00		
128	Room & Board-Rehab	700.00		14	9,800 00	9,800 00	
251	Pharmacy			56	10,000 00	2,800 00	
329	Radiology			3	600 00		
001	Total Charges				32,790.00	12,600 00	

SAMPLE A

UB-92 Claim Form

50 PAYER	51 PROVIDER NO.	52 REL. INFO	53 ASG. BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
MEDICAID	32XXXXX				20,190. 00	

57 DUE FROM PATIENT ▶

58 INSURED'S NAME	59 P.REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
Mary Jane Smith		MJ 99999 Smith A		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
999999999			

67 PRIN. DIAG. CD.	68 CODE	OTHER DIAG. CODES 69 CODE	70 CODE	71 CODE	A CODE	72 ADM. DIAG. CD.	73 E-CODE	74
518.81						518.81		

75 P.O.	76 PRINCIPAL PROCEDURE CODE	DATE	77 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
			A		B	
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE C		OTHER PROCEDURE CODE	DATE
	C		D		E	

78 ATTENDING PHYS. ID: 9999999 Dr. John Johnson

79 OTHER PHYS. ID

OTHER PHYS. ID

80 REMARKS

85 PROVIDER REPRESENTATIVE X | 86 DATE

UB-92 HCFA-1450 | DCR / Original

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

APPROVED OMB NO. 0938-0279

LTAC Hospital
123 Main Street
Anytown, WA 99999

3 PATIENT CONTROL NO: 1234567 | 4 TYPE OF BILL: 111

5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD: 040103 041503 | 7 COV'D | 8 N.C.D. | 9 C.I.D. | 10 L-R.D. | 11

12 PATIENT NAME: Mary Jane Smith | 13 PATIENT ADDRESS

14 BIRTHDATE	15 SEX	16 MS	17 ADMISSION DATE	18 HR	19 TYPE	20 SRC	21 DHR	22 STAT	23 MEDICAL RECORD NO	CONDITION CODES 24 25 26 27 28 29 30	31
MMDDYYYY	F		040103	14	2	3	12	01			

32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE SPAN FROM	THROUGH	36 CODE	36 OCCURRENCE SPAN FROM	THROUGH	37 A B C

	38 CODE	38 VALUE CODES AMOUNT	39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT
a	A1	840 00				7,000 00
b						
c						
d						05/01/03

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
100	Room & Board	885.00		14	12,390 00		
128	Room & Board-Rehab	700.00		12	9,800 00	9,800 00	
251	Pharmacy			56	10,000 00	2,800 00	
320	Radiology			3	600 00		
001	Total Charges				13,600 00	12,600 00	

SAMPLE B

Medicare Part A X-Over

Crossover Claim Form

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
Medicaid	32XXXXX			7,000 00	840 00	
Medicare	5XXXXX					

57 DUE FROM PATIENT ▶

58 INSURED'S NAME	59 P REL	60 CERT - SSN - HIC - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
Mary Jane Smith		MJ 999999 Smith		

63 TREATMENT AUTHORIZATION CODES	64 ES	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN. DIAG. CD	68 CODE	OTHER DIAG. CODES 69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 ADM. DIAG. CD.	77 E-CODE	78
518.81								518.81		

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
			A		B	
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
	C		D		E	

82 ATTENDING PHYS. ID	83 OTHER PHYS. ID	OTHER PHYS. ID
9999999 Dr. John Johnson		

84 REMARKS

85 PROVIDER REPRESENTATIVE: X | 86 DATE

UB-92 HCFA-1450 OCR/Original

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

This is a blank page…